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Original Communication

# A retrospective audit of the extent and nature of domestic violence cases identified over a three year period in the two district command units of the police service of Northern Ireland

T.R. Stevenson MB BCh BAO MRCGP (Forensic Medical Officer),
E.A. Goodall BA MSc PhD FIS (Research Design Statistics),
C.B.T. Moore PhD NTF (Research Superviser and Course Director for Masters in Forensic and Legal Medicine) *

*University of Ulster, Room W1057, CMB, Cromore Road, Coleraine, Co Londonderry, Northern Ireland, BT52 1SA, United Kingdom*

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**Abstract**

The work load of forensic medical officers (FMOs) who provide medical cover for the Coleraine and Limavady district command units (DCU) of the police service of Northern Ireland (PSNI) in dealing with domestic violence was investigated over a three year period from 1st April 2003 to 31st March 2006. A total of 128 cases involving domestic violence were identified during this three year period. There was a significant increase from 4% (32/791) in the first year to 6.6% (56/851, $p < 0.01$) in the number of cases of identified domestic violence in the second year which dropped to 4.2% (40/956) in the third year. Victims were identified in 38% of these domestic violence cases with 62% being identified as assailants. It was noted that there was a significant difference in the proportion of male assailants (96.2%) from female assailants (3.8%). Fifty-four percent of victims were noted to have injuries in accordance with the more serious injury categories of assault of actual bodily harm (AOABH) and grievous bodily harm (GBH). Domestic incidents occurred at the home in 91% of cases, with the FMO being the primary contact in 97% of cases. Alcohol was implicated in 56% of all domestic violence cases recorded.


*Keywords:* Domestic violence; Forensic medicine; Northern Ireland

## 1. Introduction

Domestic violence is seen as a world wide problem with the United Nations 4th World Conference on Women in 1995 concluding that domestic violence was an area of importance.[1] A world health organisation (WHO) report of violence and health undertook a review of 35 countries and revealed that between 10% and 52% of women reported physical abuse from an intimate partner, while 10–30% reported sexual violence from an intimate partner.[2] The prevalence has been extensively studied across the world notably within Europe, USA, Canada and Australia.[3–6] A Council of Europe analysis of 10 domestic violence prevalence studies noted that 1 in 4 women experienced domestic violence in their lifetimes and 6–10% suffered domestic violence in any given year.[7]

In the United Kingdom and Northern Ireland, domestic violence has been identified as a priority issue with an interdepartmental, interagency, statutory and voluntary agency response.[8,9] The 1996 British crime survey (BCS) reported that, of all violent incidents reported, 24% were domestic violence, with 4.2% of women and 4.2% of men stating that they had been physically assaulted in the previous year by a current or ex partner.[10,11] The 2003/04 Northern Ireland

* Corresponding author. Tel.: +44 0 7793226873; fax: +44 0 2870324375.
*E-mail address:* t.moore@ulster.ac.uk (C.B.T. Moore).

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crime survey (NICS) reported that 15% of respondents had been a victim of domestic violence in their lifetime, with 6% reporting to have been a victim in the previous year.[12]

The PSNI, as part of this response, have a role in dealing with and recording domestic violence incidents within the criminal justice system. The police service of Northern Ireland (PSNI) statistical reports revealed an increase in domestic violence offences recorded in Northern Ireland, from 8565 in 2003/04 to 10,768 in 2005/06. The combined Coleraine and Limavady DCU statistics recorded an increase of 29% from 526 (2003/04) to 676 (2005/06) domestic violence offences recorded.[13]

Forensic medical officers (FMO) have a role in domestic violence incidents in providing appropriate medical treatment, documenting injuries and assessing fitness for detention and/or interview for those who present to the police, either victim or assailant, and in the provision of reports for any subsequent legal proceedings. During the three year period researched for this study, six FMOs provided cover for the Coleraine and Limavady DCU; one senior FMO and four deputy FMOs, with an additional GP providing cover as required. Three of the FMOs had over 20 years experience, while the others had less than five years; none on the roster had postgraduate forensic qualifications at the time of this study.

Both DCUs are situated on the North Coast of Northern Ireland. Coleraine is a large University town in County Londonderry, near to the mouth of the River Bann, 55 miles (90 km) north-west of Belfast and 30 miles (50 km) east of Derry City. It is the major commercial centre in the North East of the province with a borough population of 57,000, which serves a catchment population of over 200,000. This area is composed of seaside resorts and tourist destinations such as the Bushmills Distillery and the Giant's Causeway. Coleraine PSNI station is the main custody suite for this region, dealing with victims and offenders from this extended area of North Antrim/East Londonderry. Limavady is a busy market town in County Londonderry, 14 miles west of Coleraine, with a borough population of 34,000. It has a smaller custody suite than Coleraine.

## 2. Aims and methods

The aims of the study were as follows:

To undertake a retrospective audit of the number of cases involving domestic violence that were recorded over a three year period and the nature of these cases, as seen by Forensic medical officers (FMOs) providing cover for the Coleraine and Limavady DCU of the PSNI.

### 2.1. Ethical approval

This research was conducted in accordance with all University of Ulster research governance and ethical policies. The project was assessed and approved by the local research ethics committee.

### 2.2. Data collection

FMOs that provided forensic medical service over the time period assessed were contacted verbally and in writing. Consent was subsequently obtained to review their case notes. Reviews of each of the FMO notes from April 1st 2003 to March 31st 2006 for all contacts seen were undertaken. All cases that were documented as being domestic violence in nature or involved family members or intimate partners, current and ex intimate partners were included in this study.

A structured pro forma for gathering information was completed. This included demographic information on the age, sex, influence of alcohol and/or drugs. The patients were classified as a victim or an assailant as per the FMOs notes, the relationship between the victim/assailant, the location where they were initially assessed and the nature and types of injury documented by each FMO, either from their contemporaneous notes or PACE 15 custody records and body chart. The injuries were then categorized under the CPS categories of injury, as detailed in Table 1.

## 3. Statistical analysis

The data recorded in this research were essentially categorical and therefore the analyses were conducted in the

Table 1
Categories and description of Crown Prosecution Service severity of injuries

| Common assault | Assault occasioning actual bodily harm (AOABH) | Grievous bodily harm (GBH) |
|---|---|---|
| Grazes | Loss or breaking of tooth or teeth | Injury resulting in permanent disability or permanent loss of sensory function |
| Scratches | Temporary loss of sensory functions, which may include loss of consciousness | Injury which results in more than minor permanent, visible disfigurement; broken or displaced limbs or bones, including fractured skull |
| Abrasions | Extensive or multiple bruising | |
| Minor bruising | Displaced broken nose | Compound fractures, broken cheek bone, jaw, ribs, etc. |
| Swellings | Minor fractures | |
| Reddening of the skin | Minor, but not merely superficial, cuts of a sort probably requiring medical treatment (e.g. stitches) | Injuries which cause substantial loss of blood, usually necessitating a transfusion |
| Superficial cuts | | Injuries resulting in lengthy treatment or incapacity |
| A black eye | Psychiatric injury that is more than mere emotions such as fear, distress or panic. In any case where psychiatric injury is relied upon, as the basis for an allegation of assault occasioning actual bodily harm, and the matter is not admitted by the defence, then expert evidence must be called by the prosecution | Psychiatric injury. As with assault occasioning actual bodily harm, appropriate expert evidence is essential to prove the injury |

following way. The proportion of values, $p$, falling into each category was calculated and the standard error of this proportion computed. Since proportions are binomially distributed, not normally distributed, the standard errors were calculated from the expression, $\sqrt{\frac{p(1-p)}{n}}$, where $n$ was the number of values contributing to the estimate of the proportion, $p$. Proportions were compared for statistical significance using the chi-squared test on the raw data cross-classified into two by two contingency tables. This test is known to be accurate for tables reporting at least 50 total values and also often provides a reasonable approximation for smaller data sets with the use of Yates' correction. However, in these cases, Fisher's exact test was also used to check formal statistical significance.

## 4. Results

In the three years reviewed, 1st April 2003–2nd March 2006, there were a total of 2598 cases seen by the FMOs for the Coleraine and Limavady DCU for the PSNI. One hundred and twenty eight of these were identified as being domestic violence which represented 4.9% of the total number of cases seen in the three years. A detailed breakdown of data for each year is shown in Table 2.

The ages were classified between 0 and 9 years and 70+, in 10 yearly intervals with the age ranges 20–39 comprising 65% of the total of those identified. Ages ranged from 9 to 68 years. Thirty females (30/128, 23%) and 98 males (98/128, 77%) were seen in the identified domestic violence cases.

Subjects were further subdivided into being either victims or assailants, with 49 victims (49/128, 38%) and 79 assailants (79/128, 62%). The proportion of females (27/30, 90%) who were victims was significantly different ($p < 0.001$) from those who were male (22/98, 22%). Also, the proportion of males who were assailants (76/79, 96.2%) was significantly different ($p < 0.001$) from those who were victims (22/49, 44.9%).

Notably, alcohol was recorded in 56% (72/128) of the cases seen. Nearly 66% (52/79) of the assailants and 41% (20/49) of the victims had consumed alcohol to a moderate or high degree. Table 3 demonstrates that, for the cases studied within this time period, 22% (6/27) of female victims and 64% (14/22) of male victims had consumed alcohol. Sixty-six percent of male and female assailants (2/3, 50/76, respectively) were noted to have taken high and moderate levels of alcohol (Table 4). Drug misuse was noted in 9% (12/128) of cases. Cannabis was the most frequently recorded, followed by solvents, amphetamines and benzodiazepines, with no cases of opiates or cocaine.

In terms of location of incident, 91% (117/128) domestic violence incidents were recorded to have taken place in the home of the victim or assailant, while the remaining 9% (11/128) took place in various locations such as other family member's homes, local nightclub, football pitch and a car.

Within the study presented here, a FMO was the primary contact in 97% (124/128) of cases. The remaining 3% (4/128) were seen in an Accident and Emergency Department, then subsequently seen by a FMO.

Injuries were recorded in 94% (46/49) of victims and 56% (44/79) of assailants. Fig. 1 demonstrates the overall percentage of each category of injury. Common assault was noted to be the most frequent category of injury overall (69%), with assault of actual bodily harm (AOABH) (25%) and grievous bodily harm (GBH) (6%). In the victims group, as shown in Fig. 2, the more serious categories

Table 2
Number of identified domestic violence cases with total number of cases seen from 1st April 2003 to 31st March 2006

| | 2003/04 | 2004/05 | 2005/06 |
|---|---|---|---|
| DV cases identified | 32 | 56 | 40 |
| Total number of cases | 791 | 851 | 956 |
| Percentage of DV cases against total cases seen | 4% | 6.6% ($p < 0.01$) | 4.2% |

This table gives a detailed breakdown of data for the three years reviewed, 1st April 2003 to 2nd March 2006. There were a total of 2598 cases seen by the FMOs for the Coleraine and Limavady DCU for the PSNI.

Table 3
Number of victims and alcohol consumption

| | Alcohol | No alcohol | |
|---|---|---|---|
| Female victims | 6 | 21 | 27 |
| Male victims | 14 | 8 | 22 |
| | 20 | 29 | 49 |

This table demonstrates that, for the cases studied within this time period, 22% of female victims and 64% of male victims had consumed alcohol.

Table 4
Number of assailants and alcohol consumption

| | Alcohol | No alcohol | |
|---|---|---|---|
| Female assailants | 2 | 1 | 3 |
| Male assailants | 50 | 26 | 76 |
| | 52 | 27 | 79 |

This table illustrates that sixty-six percent of male assailants were noted to have taken high and moderate levels of alcohol ($p < 0.01$).

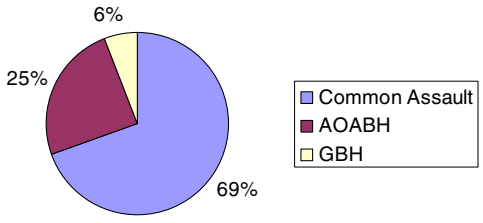


Fig. 1. Demonstrates the overall percentage of each category of injury. Injuries were recorded in 94% of victims and 55% of assailants Common assault was noted to be the most frequent category of injury overall (69%), with assault of actual bodily harm (AOABH) (25%) and grievous bodily harm (GBH) (6%).

of AOABH (47%) and GBH (7%) formed a greater proportion of the injuries sustained than that noted for assailants. The assailants were noted to have 79% of injuries within the Common Assault category with 19% in AOABH and 2% in GBH categories, as represented in Fig. 3. In addition, it was noted that in 30% (38/128) of cases there was no documented injury. In those individuals who had recorded injuries, 27% were to the head, 48% to the arms, 17% to the trunk and the remainder to the legs. In many of the cases, the person was noted to have multiple injury types and sites. These injuries ranged from bruising of various ages, abrasions – the majority in the form of scratch marks, superficial lacerations and incisions, more so to the head and arms as the number indicated. The mechanism of injury ranged from punching, pushing, kicking, and strangulation, with one case of attempted drowning and an attempted arson when petrol was thrown over a victim. A number of objects were documented to have been used; these included household furniture, a Hoover, a hammer, a brush shaft, a saucepan and in two cases a knife.

Two cases were noted of domestic violence occurring both ante and postnatally. One female victim who was six months pregnant was punched on the face and pushed off a door thus injuring her arms. She was also slapped on the abdomen by her husband. The other case involved a four month postnatal female victim who was punched in the face by her partner. In terms of other offences it was noted that there were three cases of attempted murder, six cases of threat to kill and two cases of sexual assault. There were other reasons noted for the arrest of individuals involved in domestic incidents which included breaking of exclusion or non molestation orders.

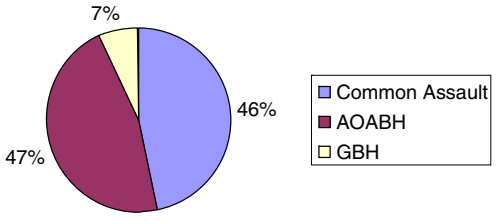


Fig. 2. Demonstrates that for victims the more serious categories of AOABH (47%) and GBH (7%) formed a greater proportion of the injuries sustained than that noted for assailants.

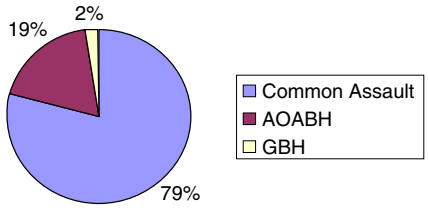


Fig. 3. The assailants were noted to have 79% of injuries within the Common assault category with 19% in AOABH and 2% in GBH categories, as represented in this figure.

## 5. Discussion

Domestic violence is a well-recognised form of violence and has wide ranging health implications for both the victim and the family. However, there are a number of difficulties in undertaking research into domestic violence and measuring its true prevalence. It is recognised that domestic violence is both under reported and under recorded both regionally and nationally. There are a number of explanations for this low level of reporting by victims - fear of not being believed, not being asked if they had been affected by domestic violence, especially by health professionals, fears of reprisal, feelings of love, shame and guilt.[19] In the 2003/04 NICS, only 39% felt that their worst domestic violence incident identified was a crime and 16% felt that is was "just something that happens" and also that 18% of respondents reported their worst incident to the police.[12] Information provided by Women's Aid Northern Ireland stated that, on average, a woman is assaulted 35 times before she seeks help from an outside agency such as the police.[18] Montgomery and Bell in a 1986 survey of 67 women in Women's Aid refuges throughout Northern Ireland reported that more than half did not inform the police because they had no confidence in them, as they were seen as being less likely to intervene in a "domestic dispute".[20] An additional factor in Northern Ireland was the reluctance on the part of victims to involve the police. Other factors included, local hostility and the associated danger for police entering certain areas which were sometimes deemed unsafe due to paramilitary threat. The under recording of domestic violence is also seen as influencing prevalence rates and is felt to relate to a lack of formal recording methods and the wide range of definitions used within research studies by government and voluntary organisations.[19,21]

There has been little research into the prevalence of domestic violence within a forensic setting and of the workload for the forensic physician in dealing with domestic violence cases in the UK and Northern Ireland. Stark et al. investigated domestic violence incidents in South London over a six month period to determine the role of the forensic physician and nature of these incidents.[14] Payne – James and Dean performed a prospective study in general forensic practice of 150 cases of injury and assault over a six month period in London. They noted that 17% of these cases were associated with domestic violence.[15]

This study was designed to determine the number of domestic violence cases seen by FMOs within two DCUs during a three year period. The authors' analysis of PSNI data indicated an increased incidence, both locally and regionally, of cases of domestic violence, also reflected in year 1 to year 2 of this audit. There are a number of possible explanations for this rise. One potential reason may be that PSNI were referring more domestic violence cases for forensic assessment and examination. In the past the police were thought to be reluctant to become involved in this type of crime, but introduction of Home Office and association of chief police officers (ACPO) guidance on domestic

violence, the establishment of domestic violence officers (DVOs) and domestic violence units (DVUs) may have changed attitudes within policing.[16,17] Police officers are now required to record and be proactive in dealing with the victims and in the arrest of perpetrators of this type of crime. This has also been associated with high profile publicity campaigns across Northern Ireland to highlight domestic violence as a crime and to increase public awareness of the available support services such as the Northern Ireland Women's Aid Free phone Helpline.[18]

The introduction of the Patton reforms has led to the formation of a regional Northern Ireland Policing Board and local District Policing Partnerships in order to monitor PSNI effectiveness and performance. The new performance targets used to assess policing strategies may also have led to greater scrutiny of all types of crime, including domestic violence. Both Coleraine and Limavady DCUs highlighted the control of domestic violence as a yearly objective and set performance targets to increase the reporting and recording of domestic violence incidents/offences. There was an additional objective to refer offenders for prosecutions in relation to domestic violence each year.[22,23] There is some merit in considering that the forensic expertise of the FMO in providing supportive evidence to secure successful prosecutions in cases of domestic violence shows society that the police and the courts do take domestic violence very seriously. If the police are more proactive in seeking prosecutions in order to demonstrate to the community that domestic violence is a crime, then the FMO is in an ideal situation to help. The fall in number of cases in the 3rd year could be as a result of reduced police referral rate to the FMO, the occurrence of more serious injuries being referred elsewhere, and historical injuries or non-physical abuse not being felt to require a forensic physician's opinion. A flaw of this audit was that information was gathered from contemporaneous notes which were not always legible or contain information to illicit if cases were domestic violence in character. This latter suggestion may highlight the need for a proforma to help as an aide memoir for the FMO in cases of domestic violence, as available from the Faculty of Forensic and Legal medicine.

Stark et al. highlighted that the forensic physician did play a role, not only forensically, but also therapeutically in the provision of appropriate medical treatment, in helping victims of violence, understanding the cause and effect of injury and the experience and training in providing written statements, giving evidence in court, providing information on voluntary support organisations and liaising with primary care agents.[14] On a wider scale, the forensic medical service may also have an important role in providing quality training to police officers in dealing with domestic violence incidents as well as being involved in regional domestic violence strategy forums.

The demographics, nature and characteristic of domestic violence and its effects are well documented with short, medium and long term effects on the victims and their families.[21,24,25] It is accepted that the majority of victims are female and are at significantly greater risk from males than males are from females, with police data suggesting that 90% of domestic violence incidents involve female victims.[12,26] The demographic findings and characteristics of the domestic violence cases in this study follow on from the 2001 British crime survey (BCS) which found that the younger person was more likely to be affected by domestic violence and the NICS 2003/04 in which 17% of 16–29 year olds had been victims compared to 15% of 30–59 year olds.[12,28] These findings may be a reflection of younger people being involved in more domestic relationships or a reluctance of the older person to report or recall violent incidents.

This study showed that overall there were more males than females seen. Further analysis demonstrated that there was a difference in the proportion of female victims compared to male victims. These findings appear to suggest that female victims were not being seen by FMOs but were possibly referred elsewhere. Personal communication with domestic violence officers (DVO) suggested that this was the case in a proportion of cases. On occasions the victim had sustained serious injuries which required immediate hospital attention rather than examination by a FMO.[27] In other domestic violence cases, there were historical injuries described by the victim but none to be noted at the time of presentation. Additionally, emotional, psychological and other non-physical forms of abuse were recorded by the DVO but were not felt to require a forensic medical opinion. The results also showed that males were significantly more likely to be assailants rather than victims, which corresponds with this view. The authors note that in day to day clinical forensic practice assailants often see themselves as being the victim, with the other party being deemed at fault for the alleged domestic incident. The FMO should therefore be mindful that in domestic violence there may be co assailants, both parties sustaining injuries but one is labelled as an assailant and the other a victim. This may also lead to a difference in the way they are handled by the police with the perceived assailant arrested and seen by the FMO and the perceived victim referred to the DVO for support, with women less likely to be arrested. It should also be recognised that while females are more likely to be victims, violence may also be initiated by a female assailant toward a male victim. The use of violence should not be condoned by either party with both male and females having rights and responsibilities within a relationship, unless there is no choice other than self defence.

In addition, alcohol was a major factor in domestic violence and this was reflected in the high proportion of assailants noted to have imbibed alcohol. Williams and McKiernan highlighted the fact that the culture of excessive alcohol intake within Northern Ireland is a significant cause of the assailants' actions.[29]

The mechanism of injuries noted in this study reflect those frequently observed types of force used by assailants and also the variety of weapons used. Findings of other surveys of victims of domestic violence have shown that they are more likely to suffer from more serious physical

injury such as extensive bruising, broken bones or being knocked out.[30,31] This study also demonstrated a wide range of injuries and patterns of injuries, the majority being scratches and bruising to the head and arms which compares to other cited reports from within Northern Ireland.[32–34] McWilliams and Spence, in a study on the civil and criminal justice response to domestic violence in Northern Ireland, quoted that on average one woman is seriously assaulted with AOABH, GBH, or attempted murder by her male partner every day.[35] This may reflect the stronger force of male aggressors on female victims and therefore the occurrence of more serious injuries.

## 6. Conclusion

The PSNI have recorded both regionally and locally an increase in the number of domestic violence incidents and offences in the three years of this study. PSNI's statistics show that there are three times as many domestic related crimes as drug offences, and there were almost twice as many domestic related crimes as car thefts and more domestic crimes than domestic burglaries.[26] This study demonstrated an increase in the number of domestic violence cases seen by the FMOs. While this represented only 5% of the total workload, this increase in workload has implications for the forensic medical service and PSNI in terms of personnel, resources, training and finances. The changes within policing in dealing with domestic violence, victim and assailant, and society's view on domestic violence and the PSNI may also be a factor in increasing the confidence of victims in seeking help and support from the police. It is therefore possible that if the PSNI are dealing with more cases of domestic violence the FMO service may also see an increase in numbers of these cases. The specialist role of FMOs may be currently under utilised by the PSNI in dealing with domestic violence but also emphasise the importance in training of FMO in dealing with cases involving domestic violence. It may be argued that the FMO should see all those involved in domestic violence albeit not needing immediate medical attention. It is also highly probable that those victims or assailants seen by the police and the FMO represent the tip of the iceberg and do not reflect the true numbers and extent of domestic violence occurring within our society. The forensic physician may have a role to play in the prevention of domestic violence as well as having this role being recognised and utilised within the criminal justice system in combating domestic violence.

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